APPENDIX O:

Mental Health Systems Improvement

Executive Summary

This report reflects the recommendations provided by stakeholders to the Department of Human Services Division of Mental Health and Disabilities Services. In the spring of 2007, the Iowa Legislature passed the S909, which contained a division on *Mental Health Systems Improvement* that directed the Department of Human Services (DHS), Division of Mental Health and Disability Services (MHDS), to form and lead planning workgroups in order to make recommendations to the Legislature. The legislation was directed at the MHDS and included requests to have recommendations reviewed by the MHMRDDBI Commission and the DHS Director. (Note: along with the Human Services Council, and the Mental Health Planning Council, the MHMRDDBI Commission serves an advisory capacity to the DHS on mental health issues).

The legislation stated:

> **"In order to build upon the partnership between the state and counties in providing mental health and disability services in the state, the workgroups established for purposes of this subsection shall engage equal proportions representing the department, counties, and service providers. The county and provider representatives shall be appointed by the statewide associations representing counties and community providers. In addition, each workgroup shall include a representative of the commission, the mental health planning and advisory council, consumers, and a statewide advocacy organization."**

In June 2007 MHDS formed six (6) workgroups that met in the months of June through October and listed their recommendations to the Systems Improvement Steering Committee. Workgroups were comprised of county, provider agency, consumer, family, advocacy, state agency and expert advisors totally nearly 100 individuals consistent with legislative direction. This report contains the recommendations from those workgroups and the steering committee comprised of workgroup-elected "Steering Committee" members. Agendas, minutes, and meeting documents were made public on the DHS website. In addition to workgroup and steering committee meetings held in the summer and fall of 2007, numerous meetings were held with provider organizations, advocacy organizations, state agencies, the Human Services Council, Mental Health Planning Council and MHMRDDBI Commission where major discussions on this initiative were held in the latter half of 2007.

This document contains the following major sections:

1. Overview of this Initiative
2. Workgroup Timelines
3. Background on Workgroups
    a. Alternative Distribution Formula
    b. Community Mental Health
    c. Core Mental Health Services
    d. Mental Health and CSA Standards & Accreditation
    e. Co-Occurring Disorders
    f. Evidence-based Practices
4. Specific Recommendations from Each Workgroup
    a. Alternative Distribution Formulas
    b. Community Mental Health Center Plan
    c. Core Mental Health Services
    d. MH and CSA Standards & Accreditation
    e. Co-Occurring Disorders
    f. Evidence-based Practices

This document does not contain specific funding requests for the legislature as such requests come from DHS as part of its budget development process.

1. Overview of this Initiative

In the winter of 2005, the Iowa Department of Health and Human Services contracted with a collaborative group of researchers at the University of Iowa to develop a white paper for the 2006 legislative session that addressed necessary first steps toward a mental health system transformation. Along with other materials, those report assisted the legislative process during the 2006 session to authorize House File 2780 which enabled the development and implementation of a Division of Mental Health and Disability Services (MHDS).

In 2007 the Legislature, in collaboration with the MHDS, developed a section of the DHS Appropriation bill (S909) entitled: "Mental Health Systems Improvement (MHSI). The MHSI legislation required the DHS/MHDS to form six major workgroups with directives to focus on major areas of interest in the mental health system to the Legislature. This report describes the workgroup development and review process, the timelines, workgroup membership and major recommendations from the workgroups and workgroup steering committee.

2. Workgroup Timelines

This following is the timeline for the development of a series of recommendations to the Iowa Legislature. There was no specific requirement for the MHDS or Commission to hold public hearings as group membership, representativeness and specific instructions to the groups was included in the enabling legislation.

Meeting dates, times and locations were published on the DHS website along with a wide range of workgroup documents, agendas, minutes and presentations. Hundreds of documents were reviewed.

There were a number of key milestones with some due late in the 2008 calendar year:

TIMELINES MHSI WORKGROUPS	Due to Commission	Due to DHS	Due to Legislature
PHASE I			
Alternative Distribution Formulas	11/1/07	12/1/07	1/31/08
Community Mental Health Center Plan	10/1/07	11/1/07	1/31/08
Core Mental Health Services	10/1/07		1/31/08
MH and CSA Standards & Accreditation	12/1/07		1/31/08
Co-Occurring Disorders	4/1/08	5/1/08	6/1/08
Evidence-based Practices		9/1/07	1/31/08
PHASE II			
Comprehensive Plan	11/15/08		12/15/08

Frequency of Workgroup Meetings

In order to attempt to meet the deadlines outlined above, each workgroup met at least six times during the summer and into the fall of 2007 to review a large number of documents about the mental health system, to participate in presentations from senior DHS staff and Technical Advisors, and to discuss documents and make recommendations to the Steering Committee. The Steering Committee had several meetings also during the summer and fall to review the minutes and products of the workgroups. The Steering Committee met weekly during September 2007 to review the recommendations made by the workgroups and developed lists of recommendations.

Agendas, Minutes, Documents Reviewed by Workgroups

Each workgroup published agendas, distributed documents, took attendance and kept written minutes of every meeting and posted all documents as well as calendar information on the IDHS/MHDS website. Meetings were held in various locations around the Des Moines area. Workgroups were asked to review documents of other workgroups as material was appropriate and a number of presentations provided by DHS staff and Technical Advisors were posted on the website for public view.

3. Background on the Workgroups

In order to meet the requirements set forth by the legislature, each workgroup had a specific focus in terms of possible improvement in the mental health system. The following are excerpts from the legislation as well as additional direction provided by staff and advisors for the workgroups to assist them in preparing recommendations.

Alternative Distribution Formulas

According to the legislation this workgroup was to:

> **"Identify alternative formulas for distributing mental health, mental retardation, and developmental disabilities allowed growth factor adjustment funding to counties. The alternative formulas shall provide methodologies that, as compared to the current methodologies, are more readily understood, better reflect the needs for services, respond to utilization patterns, acknowledge historical county spending, and address disparities in funding and service availability. The formulas shall serve to strengthen the partnership between the department and counties in the state's services system."**

This workgroup reviewed the current funding distribution formulas and methods for MH and Disability Services to counties. They reviewed approaches taken by other states and identified resources needed, anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup.

Community Mental Health Center Plan

According to the legislation this workgroup was to:

> **"Prepare a phased plan for increasing state responsibility for and oversight of mental health services provided by community mental health centers and the providers approved to fill the role of a center. The plan shall provide for an initial implementation date of July 1, 2008. The plan shall be submitted to the commission on or before October 1, 2007. The department shall ensure that key stakeholders are engaged in the planning process, including but not limited to the commission, mental health services providers, individuals with expertise in the delivery of mental health services, youth and adult consumers, family members of consumers, advocacy organizations, and counties.**

This workgroup reviewed current Ch. 230a Code standards and CMS core service standards for community mental health centers. There was a special focus in this workgroup on co-occurring disorders, children's mental health, school mental health and emergency mental health services. Specific recommendations for emergency mental health, children's mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

Core Mental Health Services

According to the legislation this workgroup was to:

> **"Identify core mental health services to be offered in each area of the state by community mental health centers and core services agency providers. The workgroup for this task shall be established no later than August 1, 2007. The core services shall be designed to address the needs of target populations identified by the workgroup and the services may include but are not limited to emergency services, school-based mental health services, short-term counseling, prescreening for those subject to involuntary treatment orders, and evidence-based practices. The division shall submit to the commission on or before October 1, 2007,**

proposed administrative rules and legislation to amend chapter 230A as necessary to implement the core services beginning July 1, 2008. "

The workgroup reviewed the current matrix of services included in the Medicaid contract with Magellan Behavioral Health regarding services to be provided as well as other potential "core services" that could be available for children, youth and adults. Specific core services will minimally include: emergency mental health services, etc. Each CMHC or CSA will be expected to contract or have a letter of agreement with a local inpatient psychiatric unit to serve consumers in need of inpatient hospitalization. The workgroup will identify resources needed, anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup. Specific recommendations for emergency mental health, children's mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

Mental Health & Core Service Agency Standards & Accreditation

According to the legislation this workgroup was to:

"Identify standards for accreditation of core services agencies that are not a community mental health center but may serve as a provider approved to fill the role of a center. Such core services agencies could be approved to provide core mental health services for children and adults on a regional basis."

This workgroup reviewed the current CMHC standards (Ch230a) and recommended revisions according to the delineation of core services to allow CMHCs to operate under the direction of the DHS MHDS. The workgroup recommended accreditation standards for core service agencies as well as emergency mental health and children's services. A review of standards from other states occurred. Consideration by this workgroup was given on supporting continuous quality improvement activities, the inclusion of co-occurring and systems of care principles in the standards. The workgroup identified resources needed, discussed anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup. Specific Ch230a changes were developed. Specific recommendations for emergency mental health, children's mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

Co-Occurring Mental Health and Substance Abuse Disorders

According to the legislation:

"The division and the department of public health shall give priority to the efforts underway to develop an implementation plan for addressing co-occurring mental health and substance abuse disorders in order to establish a comprehensive, continuous, and integrated system of care for such disorders. The division and the department of public health shall participate in a policy academy on co-occurring mental health and substance abuse disorders as part of developing an implementation plan for commission review by April 1, 2008."

In the summer of 2007, per the above direction, IDHS and IDPH resumed meetings of the COD Policy Academy. DHS/MHDS engaged the services of Dr. Kenneth Minkov and Dr. Chris Cline to provide support and technical assistance on reviving the Policy Academy as well as facilitate the design and implementation of a model for co-occurring disorders. Through collaboration between the Policy Academy and the Workgroup a Charter Document (see Appendix) was prepared to begin implementation of systems change across agencies and throughout the mental health and substance abuse system. The workgroup recommended ongoing development of the COD model through implementation of the Charter document with a wide range of organizations and agencies.

Evidence-based Practices

According to the legislation this workgroup was to:

> **"(1) Begin phased implementation of evidence-based practices for mental health services over a period of several years. (Not later than October 1, 2007, in order to provide a reasonable timeline for the implementation of evidence-based practices with mental health and disability services providers, the division shall provide for implementation of two adult and two children evidence-based practices per year over a three-year period."**
>
> **(2) The division shall develop a comprehensive training program concerning such practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa consortium for mental health and mental health service providers. The division shall consult with experts on behavioral health workforce development regarding implementation of the mental health and disability services training and the curriculum and training opportunities offered.**
>
> **(3) The department shall apply measures to ensure appropriate reimbursement is available to all providers for the implementation of mandated evidence=based practices and request appropriate funding for evidence=based practices from the governor and general assembly as part of the implementation plan. The implementation plan shall be submitted to the governor and general assembly on or before January 31, 2008.**
>
> **(4) The department shall provide the commission with a plan for review to implement the provisions of this paragraph "f".**

This workgroup developed a three-year sequence to implement a range of children, youth and adult EBPs that also carefully considered the needs for staff orientation, training and supervision in EBP areas. The focus on workforce development training was recommended for all levels of mental health and disability services including CMHCs, MHIs, and State Resource Centers; DHS operated Juvenile facilities, PMICs and Core Service Agencies. The development and implementation of a Mental Health and Disability Training Institute was recommended where training programs must demonstrate that they employ evidence-based practices for teaching/training. The workgroup began the identification of resources needed, anticipated costs for implementation, and requirements for rule, code and statute changes to implement recommendations of the workgroup. An interagency collaborative workforce development group was recommended with ongoing mentorship from the Annapolis Coalition on Workforce Development. Specific recommendations for emergency mental health, children's mental health, school mental health and co-occurring disorders are contained in subsequent sections of this document.

4. Discussions and Review with the MHMRDDBI Commission

A number of meetings were held with the MHMRDDBI Commission over the time period when the Workgroups and Steering Committee met. Updates as well as draft reports were provided to the Commission on the following dates: August XX, September XX, and October XX, 2007. Individual workgroup and steering committee members presented summary reports to the Commission at its annual retreat. Minutes of the Commission meetings reflect that draft documents were distributed to Commission members, workgroup and steering committee members as well as project technical advisors on a number of occasions before the distribution of this current draft.

5. Recommendations from the Workgroups

The legislation related to this project did not specify the manner in which recommendations were to be obtained, nor in what manner they might be weighted or prioritized. Therefore, recommendations are not listed in order of priority or importance. While there was often considerable discussion about some recommendations, there was often consensus on many of them.

Following an election by the workgroups of steering committee “representatives” the steering committee met for several weeks to summarize the recommendations. There was often consensus on many of the recommendations but there was also considerable disagreement on a number of recommendations. The steering committee was often reminded to attempt to remain within the scope of the charge for the workgroups from the legislature. However, some members of the steering committee persisted in requiring discussion and recommendations on a wide range of issues outside of the scope of the specific, individual workgroup.

The following sections of this document list the workgroup recommendations as prepared by the Steering Committee. Considerable editing was required to eliminate redundant recommendations and capture the intent as well as, when indicated, specific language from the workgroups. During later drafts of this document there were dozens of email edits and recommendations circulated regarding the recommendations and follow up meetings held with DHS staff and workgroup/steering committee members. Consideration was given to preparing a section on “minority views” but this was not included. As can happen in committees, there was often major disagreement among workgroup and steering committee members on recommendations despite attempts to reach consensus. A particularly contentious series of discussions were held related to the Alternative Distribution Formula recommendations.

A. Alternative Distribution Formula Workgroup

Workgroup Members

Technical Advisor

Dr. William Hudock

DHS Representatives

Jim Overland

Harold Templeman (former DHS employee)

County Representatives

Linn Adams

Jill Eaton (Alternate)

Karen Walters-Crammond

Service Provider Representatives

Dave Becker

Earl Kelly

Commission Representatives

Jane Halliburton

Rick Hecht

MH Planning and Advisory Council Representatives

Teresa Bomhoff

Michael Winchell

Consumer Representatives

John Curtis

Todd Lange

Statewide Advocacy Organizations Representatives

Mardi Deluhery

Richard Shannon

Margaret Stout

The Alternative Distribution Formula (ADF) Workgroup would like to acknowledge the following steps, which the Legislature has taken in response to the recommendations of the MH/MR/DD/BI Commission:

- 150% of Poverty level was established as the standard eligibility guideline for disabilities services that are provided by counties.
- Service eligibility was changed on 7-1-07 so that eligibility is determined by the county management plan in the county of residence and paid for by the county of legal settlement.
- Community Mental Health Centers, psychiatrists and inpatient psychiatric units are being funded on a cost based system (For Medicaid clients only). Most Community Mental Health Centers had been operating at a financial loss.

NOTE: Cost based reimbursements also apply to other Chapter 24 accredited providers – it is not limited to just CMHC's – per HF909.

- A new Division of Mental Health & Disability Services was established within the Dept. of Human Services.

The present situation:

- The original formula to distribute mental health and disability funds was modified in the last 12 years with calculation changes in an effort to channel the funds to the counties where the county property taxes, allowed growth, MHDD community services, and property tax relief were not sufficient to address the service needs.
- The State Legislature determined that the calculation changes were necessary to encourage some counties to spend their fund balances and adequately levy county dollars for mental health.
- The calculation changes have increased the level of complexity and obscured a full understanding of the actual costs and expenditures.
- The present formula used is too complicated to be a transparent transaction.

The ADF workgroup was asked to explore methodologies that:

- Are more readily understood,
- Better reflect the needs for services,
- Respond to utilization patterns,
- Acknowledge historical county spending,
- Address disparities in funding and
- Promote service availability.

The ADF Workgroup used the following values to identify a possible replacement formula for distributing fund appropriations from the State's General Fund and the Health Care Trust Fund:

- Simplification
- Flexibility
- Adequate to cover core services funding so access to core services is available state-wide.
- Adequate to allow for additional services above core services.
- Replacement of legal settlement as a basis for determining allocations with the determination of where the individual receives services
- Better meet the needs of the service population
- Allow money to follow the person

The ADF Workgroup recommends a two-step process in creating a new distribution formula:
- Making adjustments to the present formula
- Creating an alternative distribution formula to reach a system of mental health funding that reflects the values outlined above.

The elimination of legal settlement will not occur until an alternative distribution formula is developed, which is the goal of the ADF Workgroup. Through an alternative formula, the allocation of money will follow the person in that it will be based on where an individual receives services rather than where they reside.

Description of the Present Distribution Formula

The current formula for the allocation of funds to the counties includes growth appropriation dollars and the MHDD Community Services appropriation dollars. Over the years a number of adjustments have been made to the formula to insure that money goes to the counties with the greatest need. Greatest need has been defined as a county with a fund balance below 10%.

This is how the formula worked for the allocation of the money in fiscal year 2007:

- The first step is to determine the allowed growth allocation. In 2007 this was $12,000,000, which was based on the latest general population estimate for each county.
- The second step is to determine the per capita allocation, which is based on the latest general population estimate for eligible counties. A county is eligible if:
  - ⇒ The county levied 100% in the current year,
  - ⇒ The county had a fund balance below 25% in the previous two years, and
  - ⇒ The county had net expenditures below $116.77 per capita in the previous year.
- The third step is to determine the community services allocation of which 50% is based on the latest general population estimate and 50% on the most recent poverty population data. In 2007 this amount was $17,727,890.

These three funding pools add up to an initial state allocation of $61,853,614.

- Counties with a fund balance of less than 10% are now allocated additional funds,
- Those counties with a fund balance less than 5% will be awarded an amount equal to 3% of their gross expenditures last year.
- Those counties with a fund balance between 5-10% are awarded 2% of their gross expenditures last year.

Instead of $61,853,614, the state only appropriated $54,189,038 to counties for Mental Health Allowed Growth so we need a mechanism to get from the initial allocation to the final appropriation – that mechanism is called the withhold factor. The withhold factor is an equitable way of reducing each county's allocation by a proportionate amount of the shortage in the appropriation.

For 2007 the withhold factor is $7,664,576, the difference between the initial allocation and final appropriation.

The withhold factor only affects counties with fund balances between 10% and 25% and is calculated by dividing the amount of the state appropriation that is left over after the initial allocation of funds to counties and the additional award to those counties having a fund balance less than 10%. Each county's initial allocation is then multiplied by the withhold factor to get the final allocation.

But one more factor is taken into consideration and that is the ledge. The ledge says that a county can only lose an amount of money equal to the amount by which its fund balance exceeds 10%. After these calculations are completed and the ledge factor applied, the result is the final allocation for each county.

Adjustments to the current formula have been made because of a number of factors. Over time, the freezing of the dollar amount counties are allowed to raise through property taxes has resulted in large fluctuations in the levy rate in some counties, a steady decline in the levy rate for some counties, and a continued wide variance among the counties. There is no relationship between the amount of money available to a county through property taxes and property tax relief and the amount of money needed to provide services to its citizens. So the base level of funding is uneven.

Adjustments have also been made to ensure that state funds are not used to replace county dollars. Thus, the level of fund balance and the extent to which counties levy the maximum amount allowed have become large factors in the formula.

The current formula ignores many of the factors that contribute to the level of need in a county. These include such things as the number of individuals actually receiving services, the levels of service they need, and the array of services offered by the county. It also does not allow for a reasonable transition from using legal settlement as the primary factor in determining which

county will pay for services for a particular individual. It has long been a goal in the state to move to payment based on residency rather than legal settlement. Currently, counties continue to pay for individuals, even if they move out of the county. If the state funding formula would allow for funds to follow the individuals as they move, legal settlement could be eliminated as a basis for payment responsibility.

Proposed Budget Numbers Formula

The ADF Workgroup proposes the following budget numbers formula, using FY09/10 as an illustration:

A. Determine the current Fund 10 Budgeted Expenses (i.e. FY09/10)

B. From the Fund 10 amount, subtract the following amounts:
-Unallowable Expenses
-FY09/10 Budgeted Revenues other than Allowed Growth
-FY07/08 Accrual Fund Balance (or for an earlier calculation, use FY06/07 Accrual Fund Balance)
-The FY09/10 County Property Taxes budgeted for Fund 10
-Any amount of County Property Taxes that the county could have levied, but did not levy

C. Use the subtotal from the above calculation and add a % of the current (i.e. FY09/10) Fund 10 Budgeted Expense that represents a reasonable fund balance target. 10-15% has been suggested as reasonable.

D. The resulting figure is the Gross Allowed Growth Needed

If the Legislature appropriates less than the Total Gross Allowed Growth Needed, each county's share would be proportionately reduced.

Under the proposed budget numbers formula, several issues would have to be addressed for the formula to work.

- Counties would have to prepare budgets that reasonably addressed the level of services needed in the county. It appears unlikely this has occurred since the number of MH dollars each county was allowed to spend has been frozen since 1996. The dollars available drive the services that can be offered.
- Administrative rules would have to be established to define unallowable expenses.
- It appears to be a labor-intensive process to review each of the 99 county budgets each year.

The ADF workgroup concluded –

- Instead of recommending an "interim" formula such as the proposed budget numbers formula and then a "final" alternative formula –
- The workgroup would recommend some "adjustments" to the present formula and then a "final" alternative formula.

Most efforts should be expended to implement the final (or alternative) formula as soon as possible. There was consensus that the longer-term recommendation (alternative formula) is where the committee wishes to go.

Points Regarding a Formula Change or Alteration

The ADF workgroup made these points regarding the alteration of a distribution formula or switching to an alternative formula:

- There must be winners and losers if the total dollars remains the same.

- Altering any variable of the formula will lead to a different set of winners and losers and to different degrees of gain and loss.
- Formulas can reflect principles (e.g. equal weighting based on population, distribution based on cost of services provided, etc.) but use of such formulas will lead to winners and losers compared to the status quo.
- The current formula reflects both principles and years of political adjustments that resulted in some counties getting more and some getting less. Any change or simplification of the formulas will result in unraveling of some of these political adjustments. As such, it will create both winners and losers in ways that may be unanticipated.
- Different stakeholders will reach different conclusions regarding whether any changes to the existing formula are fair. The open question is how one supports one's conclusions regarding the comparative fairness of different formulas. The committee early on reached the conclusion that some of the adjustments in the existing formula were both difficult to understand and potentially less fair than the formulas that recently have been discussed.
- The committee gets to make recommendations, but ultimately the legislature gets to decide whether the recommended changes (or some variation of them) are preferable to the existing formula. Their decisions likely will be based both on the logical strength of the recommended formula and on the political realities that confront the various counties.

Other Alternative Formulas explored but discarded

1. Use MH/DD population rather than general population in the present formula – The ADF Workgroup couldn't run these numbers with any accuracy since we could not determine an unduplicated count of consumers in each county.

2. Use SSI population per county rather than general population and poverty in the present formula – The ADF Workgroup was unable to test this alternative for lack of accurate numbers of consumers.

3. Use a budget numbers formula instead of the present formula - Instead of using population as the base, the base is the level of expenses each county anticipates it will need to spend to reasonably address the needs of its consumers.

Adjustments to the Present Formula

The ADF Workgroup recommends submitting the following changes to the 2008 Legislature, to be effective starting with the FY 09 Allowed Growth Calculation. The legislative recommendations should include two items, which are required for a county to be eligible for funds through the MHDD Community Services and Allowed Growth formula:

- The county would be required to levy at 100% of maximum dollars except where the cost per thousand levy rate will exceed a reasonable maximum rate per $1000 valuation. The ADF Workgroup initially is recommending that the maximum rate be $3.00, but others involved in property tax policy are recommending $2.50. Only a few counties' maximum levies exceed $2.50.
- The county's fund balance would have to be less than 15%.

The fund balance used in the calculation would be one year earlier than the current formula.

For example – for FY 09/10, in the present formula, the FY 08/09 Fund 10 balance is used (1 year prior). The proposed adjustment to the current formula would use the FY 07/08 Fund 10 balance- 2 years prior).

With the fund balance adjustment described in the previous paragraph, the law can also require that the distribution of funds through the MHDD Community Services and Allowed Growth formula be calculated by January 1 for the subsequent fiscal year, and by July 1, 2008 for FY 09.

The ADF Workgroup identified 32 counties that are currently or will likely soon be experiencing a funding crisis, based on fund balance, percent of maximum levy, and counties' reports of service reductions and/or waiting lists.

If the recommended changes in percent of maximum levy and percent of fund balance would be used for the FY08 formula using FY06 fund balances, all of the counties with funding crises would receive the same amount or more funding than with the current formula.

The Alternative Formula

The Alternative Formula proposed is: county allocation = client/consumer #'s X case rate.

The Alternative Formula we are recommending is a conceptual formula that will reflect true costs - one that will be sensitive to:

- Changes in the number of consumers
- The intensity of need
- The level of services provided as well as other factors that may be important such as ability to pay, poverty rates, etc.
- Other resources available to those individuals (natural supports, Medicaid, etc.)

Two important tasks must be completed to move from the present formula to the proposed Alternative Formula:

1. Establishing an accurate, unduplicated count of consumers

Not having an accurate unduplicated count of consumers compromises the accuracy of any formula or fairness of any policy where the money follows the person (where the allocation for a case goes to the county managing the case).

The first year of services will be completed June 30, 2008, in which services were managed by the county of residence but paid for by the county of legal settlement. It was not the exclusive arrangement for payment of services for a consumer, however.

There were still instances when some of the services provided were paid by the county of residence, not the county of legal settlement. Another factor affecting unduplicated count of consumers was in situations where some counties allocated their funds to service providers as a block grant, therefore, no count of consumers was done.

These factors (and possibly others) cause wide fluctuations in numbers of consumers served being reported. The situation has created difficulty determining an unduplicated count of persons being assisted.

Specific rules and definitions should be developed for reporting # of MH/DD persons being served so an unduplicated count of persons being served can be achieved. The present definition and method of reporting is not working. Counties are counting consumers served in different ways.

2. Establishing a Case Rate

This new methodology will be well aligned to the cost of service. By this we mean that there is a difference in cost based on severity of need or based on intensity of service provided. These two

different approaches are often reflected through level of functioning (severity of need) measurements and through level of care (intensity of services) measurements respectively. We could use one or both of these types of measures.
The benchmarks will be:

- The data is understandable in simple terms and
- There is wide agreement that the data is accurate and complete

A functional assessment team has been meeting since May 2004. A case rate methodology is not yet established but pieces of the process are underway to establish a case rate methodology. To achieve the alternative distribution formula, the following steps should be completed:

- Define the factors which group people together
  - ⇒ Receiving Medicaid or not receiving Medicaid
  - ⇒ High, medium, low functioning*
  - ⇒ Severity of illness based on -
    - --Developmental disability
    - --Mental retardation
    - --Chronic mental illness
    - --Mental illness

- Design service packages and estimated costs based on -
  - ⇒ Core services
  - ⇒ Additional services
  - ⇒ A determination of costs that will be included in the case rate

- Need data systems in place to track costs & information**

- Address how the case rate might work if it is adjusted by the county's levy and fund balance.
- Establish a stop loss pool to provide additional funding for individuals whose service costs fall significantly outside the parameters of the rate cell that is the basis for their payment.

*** Standardized Functional Assessment Group - LOCUS software (for MH/MR/DD/BI cases) purchased for 6 demonstration counties and was offered to counties on a voluntary basis by January 2007, although counties do not yet have access to the scores through the software. ICAP software (for MR and DD cases) purchased for 4 demonstration counties in January 2007.**

The State Legislature authorized an appropriation of $260,000 in HF 2780 for FY 2007 to move these tasks forward. The same appropriation was provided in HF 909 for FY 2008. These funds could be used to make significant progress toward the development of the case rate methodology.

** ISAC has obtained funding through IOWAccess Fund to begin establishing a statewide database. This statewide database will be able to record all necessary information, including functional assessment data and the cost of services. The basic system should be available in 2008.

<u>How Case Rates Could Work</u>

A case rate is a statistically determined cost of providing services for a cluster of individuals with the same disability or disabilities and similar levels of functioning.

Step 1. Establish case rates.
Assume we have released an RFP, hired a consultant, they have analyzed the data, and we now have 25 rate cells. The rate cells represent quarterly dollar amounts needed to serve the average client in that rate cell.
Rate Cell A = $1,000 Rate Cell B = $4,000 Rate Cell C = $2,500

Step 2. County X sends a current case count for each rate cell.
Rate Cell A = 15 Rate Cell B = 24 Rate Cell C = 17

Step 3. Calculate total dollars needed.
Rate Cell A: 15 X $1,000 = $ 15,000
Rate Cell B: 24 X $4,000 = $ 96,000
Rate Cell C: 17 X $2,500 = $ 42,500
$153,500

Step 4. Calculate quarterly allocation to County X.
(Total dollars needed) – (One fourth of the minimum county levy for Fund 10) = County X Allocation
$153,500 – ($285,420 X ¼) = $82,145

The final determination of a county's allocation should include some consideration of each county's fund balance.

- An operational definition should be established for a maximum fund balance (maybe the 10% that is used in the withholding calculation now) before it is used in the calculation of a county allocation.
- This definition should consider whether a county levies more than the minimum (maybe a proportional calculation)
- or maybe there was some plan (strategic) about levying extra funds to accomplish a specific task (such as mandated core services).

Any of these ideas could be incorporated in the case rate calculation and the fund balance component.

The Appendix shows a comparison of the present formula, the proposed interim formula, and the proposed alternative formula.

As the Alternative Distribution Formula Workgroup was meeting other issues surfaced about which we wanted to make recommendations but they were outside the scope of our charge. As a result, we are making a separate report discussing those issues and sharing our recommendations.

B. Community Mental Health Center Plan

Community Mental Health Workgroup Members

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Statewide Advocacy Organizations Representatives

Carol Porch

Recommendations from the Workgroup:

1. THE CMHC Workgroup supported the Core Services Workgroup recommendations and added the following:

> *"Prevent any unfunded mandates. Address resource needs related to the uninsured, underinsured, uncompensated care, etc. Ensure that adequate resources are dedicated to successfully implement required changes related to the* Mental Health Systems Improvement Process.
>
> a. The CMHC Workgroup recommends the following:
>
> - Review the current rate of payment for mental health services to determine if the current rate covers the actual cost of service provision. Include a review of the rates for substance abuse services.
>
> - *"Create eligibility criteria for core services which:*
>   - *Determines service access by individualized clinical eligibility/medical necessity as determined by a standardized functional assessment.*
>   - *Addresses barriers for people who are uninsured or under-insured that hinder service access.*
>
>   *Ensures access to mental health services for people of all ages, regardless of ability to pay (i.e., includes children and older adults, is not limited to adults."*
>   - *Focuses on the priority populations of:*
>   - *Anyone as determined by individualized clinical need is eligible for Outpatient Services.*

- *Anyone experiencing a self-defined psychiatric emergency is eligible for Emergency Services.*
- *Individuals experiencing SMI/SED eligible for an additional array of Specialized Community Based Service.*

b. The CMHC Workgroup recommends clarification that *"anyone regardless of ability to pay"* does not mean services would be provided free of charge but does mean following standardized financial eligibility criteria.

c. The CMHC Workgroup also recommends the implementation of a standardized sliding fee schedule for persons above the financial eligibility criteria.

2. Establish the State Mental Health Authority as the statewide oversight entity for required core safety net services and of the CMHC's as providers of those services. Also, establish the State Mental Health Authority as the statewide oversight entity of other mental health services and service providers (i.e., accrediting body).

3. Establish a statewide public safety net and utilize the community mental health centers as the public safety net with the responsibility to ensure the statewide availability of required core safety net services that includes 24/7 access to emergency services.

4. Maintain the role of other Core Service Providers as a valuable part of the total system of care.

5. Establish a process for the State Mental Health Authority to determine service areas or regions to be served by the CMHCs for the required core safety-net services.

6. Ensure people with mental health needs have access to core services regardless of their ability to pay (i.e., to fund uninsured, underinsured) following clinical eligibility criteria, financial eligibility criteria, and implementing a standardized sliding fee schedule for persons whose income exceeds financial eligibility criteria.

7. Prioritize public funding and service provision of Required Core Safety Net Services to persons of any age who meet priority/targeted population criteria (as outlined in the Core Services Workgroup Report).

8. Determine the role, relationship, and responsibilities of the State Mental Health Authority and the counties regarding financing and managing the public Mental Health System. The CMHC Workgroup is recommending:

   a. State Mental Health Authority responsibility for funding services identified as Required Core Safety Net services (i.e., non-federal portion of Medicaid; funding for uninsured/underinsured),
   b. State Mental Health Authority responsibility for the financing of the non-federal portion of all other community level mental health services funded through Medicaid ***for all ages.***
   c. Individual county responsibility for funding other mental health services based on local need as identified in the County Management Plan. This ***includes*** responsibility for other local service needs for children.

9. The CMHC Workgroup is recommending that responsibility for the non-federal portion of community level mental health services remain with one entity and become the responsibility of the State Mental Health Authority and of Medicaid. **Note:** There was considerable discussion in the workgroup about delineation of financial responsibilities for payment for the non-federal portion of mental health services funded through Medicaid being split between the state and the counties. State responsibility for financing the non-federal portion of some Medicaid funded mental health services (i.e., required Core Safety Net services) and County responsibility for financing other Medicaid funded mental health services can result in competing interests, influence service provision based on funding responsibilities rather than clinical need and/or

result in other unintended consequences that can negatively impact service access and provision for adults, youth, and their families.

10. Phase the implementation of Mental Health Systems Improvement recommendations over a 3-to-5 year time period.

11. Revise *Chapter 230A: Community Mental Health Centers* to incorporate the recommendations of the Mental Health Systems Improvement process.

12. Revise *Chapter 24* to:

a. Establish minimum standards for accreditation of CMHC's as an agency with responsibility for required core safety net services.
b. Change accreditation of other Mental Health Service Providers. Focus on accreditation standards for services rather than providers (i.e., Providers would then need to meet standards for a service to provide that service).

13. Revise, amend or develop other related areas of Iowa Code and/or Administrative Code to be consistent with Mental Health Systems Improvement recommendations.

- Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Rep.'s, Commission, IME, etc.).
- Revise CMHC Code to incorporate recommendations about CMHC's as safety providers responsible for Core Required Safety Net Services.
- Include language about the role of the State Mental Health Authority
- Assess accreditation process of other MH service providers (i.e., Accreditation by individual service or by provider entity?). Incorporate necessary changes as it relates to changes, additions of Medicaid services.
- Utilize the support and expertise of others such as consultants and legislative staff
- Ensure accreditation standards for mental health service providers and related mental health service standards (i.e., Habilitation Services, Remedial Services, and Psych.Rehab. Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations.
- Include an assessment and revisions to code related to voluntary and involuntary commitments.

14. Convene a workgroup of representative stakeholders to analyze the amount of funding needed for safety net services that address the financing for uninsured, underinsured, uncompensated care.

- Assess how current county/state funding is being utilized (i.e., Determine what is being matched to Medicaid, what is not, etc.).
- Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what segments? Where are responsibilities shared?).
- Determine if there is existing funding that can be leveraged for Medicaid services.
- Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy in program for people with disabilities.
- Assess the pros, cons, and unintended consequences related to funding responsibilities and financing mechanisms.
- Utilize a financing model that supports the service needs of consumers and youth, removes cons and other unintended negative consequences, promotes collaboration (and eliminates cost shifting) across responsible parties, and contributes to the successful implementation of Mental Health Systems Improvement.

- Coordinate the findings of this group with MHDD, IME, and Magellan regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.

15. MHDS, IME, and Magellan work together to revise the Medicaid State Plan and the various Medicaid service options related to MH so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:
    - Add/revise services that support the financing of core required safety net services (i.e., Crisis Intervention Services, Intensive Case Management Services, Peer and Parent Support.).
    - Utilize Medicaid administrative funding to support the financing of core required safety net services such as Screening and functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
    - Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other "typical" CMHC services can be provided in any community location.
    - Revise Hawk-I (S-CHIP) to include core required safety net services and to offer a similar MH benefit package as Medicaid.
    - Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, and Psych. Rehab. Services, Children's Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.

16. MHDS, IME, and IDPH work together to:
    - Conduct an analysis of and work together to resolve administrative, policy, and funding related to the provision of services to persons with co-occurring disorders.
    - Resolve inconsistencies/remove barriers between funding streams for mental health and substance abuse services.
    - Work towards integrated funded for persons with co-occurring disorders.
    - Institute joint outcomes regarding service provisions for persons with co-occurring disorders.
    - Develop a data tracking system that can track and identify services provided to persons with co-occurring disorders across services systems (i.e., Mental Health Services, Substance Abuse Services, Inpatient Treatment, etc,). Implement this data tracking system within 3 years.
    - Complete a review of the rates paid for mental health versus substance abuse services to ensure that the rates are comparable to one another based on level of service, qualifications of staff, etc.

C. Core Mental Health Services

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- Carol Porch

Statewide Advocacy Organizations Representatives
- Alice Book
- Patricia Schafer

Recommendations from the Workgroup:

1. Ensure that Iowans of all ages have access to a comprehensive array of core mental health services and that services can be accessed statewide.

2. Ensure emergency services can be accessed anytime of the day or night (i.e., 24/7) throughout the state for anyone, any age experiencing a psychiatric crisis.

3. Ensure timely access to all core services (including psychiatry and emergency services).

4. Standardize the target population definitions used for adults (i.e., Chronic Mental Illness is sometimes used, Serious Mental Illness is sometimes used), so that everyone is using the same one. Use the term Serious Mental Illness and create a definition that is in keeping with the Federal definition for Serious Mental Illness.

5. Create and implement a definition/targeted population of serious emotional disturbance (SED) for youth that is in keeping with the Federal definition for Serious Emotional Disturbance.

6. Create eligibility criteria for core services which:
- Focuses on priority populations and determines service access by clinical eligibility/medical necessity and financial eligibility criteria (i.e., Outpatient and Emergency Services for anyone in need regardless of ability to pay; “Specialized CSS/CBS Services” for individuals experiencing SED/SMI).
- Addresses barriers for people that hinder service access related to insurance limitations or having no insurance.

- Ensures access to mental health services for people of all ages (i.e., includes children and older adults, is not limited to adults).
- Addresses service delivery barriers for providers that results in achieving what is expected with service provision.

7. Ensure that youth experiencing serious emotional disturbance and adults experiencing serious mental illness have access to Specialized Services (IE: the services that can be provided anywhere in the community) locally, in their own homes and their own communities.

8. Implement intensive case management services as a core services (and an EBP) for both adults experiencing serious mental illness and youth experiencing serious emotional disturbance by July 1, 2008.

9. Utilize the community mental health centers as the public safety net with the responsibility to ensure the statewide availability of core services and 24/7 access to emergency services. Ensure that the new standard of care focuses on local availability, personal contact, and local coordination of services.

10. Maintain the role of other Core Service Providers as a valuable part of the total system of care.

11. Address Behavioral Health Workforce Shortages in the following areas:
- Psychiatry,
- Other mental health professionals (i.e., doctoral-level Psychologists; other licensed practitioners; BA and para-professional level staff).
- Develop an organized statewide program to recruit and retain mental health specialists.
- Look at other models to address the gap in psychiatry such as:
  - Telemedicine
  - Implement specialized training in mental health for primary care physicians
  - Utilize other medical professionals (IE: primary care physicians, ARNP's, physician assistants, etc.) as "extenders" of psychiatrists.
  - Define an organized statewide program to recruit psychiatrists and other behavioral health workforce professionals where there are shortage areas.

12. Ensure the new standard of care fro mental health supports an integrated health model (e.g. co-location of related service providers; integration of mental health with primary care physicians; etc.).

13. Assemble an Acute Mental Health Care Task Force including relevant agencies (i.e., Providers, County Attorneys, Judges, Law Enforcement, Child Welfare, Schools, Hospitals, CPC's, etc) consumers and family members to review models and approaches in acute mental health services to determine how such services should be carried out in Iowa.
- Include representation from the Core Services Workgroup on the Emergency Services task Force.
- Include representation from Core Services on the Acute Care Task Force.
- Ensure that the work of Core Services Workgroup, The Emergency Services Task Force and the Acute Care Task Force are well coordinated.

14. Develop education/training processes of all service providers in Co-Occurring Disorders. Have MHDS and IDPH work together to address barriers in policies, procedures and reimbursement mechanisms related to providing services to persons with co-occurring disorders. Ensure data tracking methods include the ability to adequately track persons with co-occurring disorders (i.e., service and outcomes data).

15. Create a state level/statewide funding pool specifically for the purchase of medications for people who are uninsured/underinsured. Allow this funding stream to be utilized for lab testing, other services, etc. directly related to medication management. A statewide Medication Assistance Program with oversight and management by MHDS is recommended in order to secure additional resources such as:

- Resources related to administrative costs of managing Medication Assistance Programs.
- Prescription assistance programs with pharmaceutical companies (i.e., in kind contributions, reductions in purchasing, etc.).
- Federal funding or other resources to support the purchasing of medications.

16. Prevent any unfunded mandates. Ensure that adequate resources are dedicated to successfully implement required changes related to the redesign of the Iowa mental health system.

- Address resource needs related to the uninsured, underinsured, etc.
- Identify approaches to deal with increasing levels of uncompensated care.
- Ensure that any requirements for CMHC's and Inpatient facilities to have a letters of agreement with one another is not misinterpreted to mean CMHC's have financial responsibilities for the cost of inpatient care (and vice versa).

17. Ensure that the shift to community based service provision is supported through all related processes across agencies. Utilize the State Mental Health Authority as the lead agency responsible for the oversight, management, and implementation of Mental Health Systems Improvement efforts. Include consumer, family member, and other key stakeholders as relevant.

18. MHDS conduct a cross system review of all related administrative processes, policies and procedures, accreditation standards, Iowa Code, reimbursement mechanisms (i.e.; grants, fee for service, etc.), funding streams (i.e.; Medicaid, state/county funds, etc.), Medicaid Service Definitions, Medicaid Options (i.e.; current construct of the state plan, other options, etc.). Work with relevant agencies to make revisions and/or additions as necessary to carry out the implementation of Mental Health Systems Improvement efforts.

19. MHDS, IME, and Magellan work together to revise the Medicaid State Plan and the various Medicaid service options related to MH so that Medicaid Service Options are consistent with and support the Mental Health System Improvement efforts:

- Add/revise services that support the financing of core required safety net services (i.e, Crisis Intervention Services, Intensive Case Management, Peer and Parent Support, etc.).
- Utilize Medicaid administrative funding to support the financing of core required safety net services such as Screening and functional assessments related to inpatient psychiatric /residential/ICFMR care (known as Certification, Re-certification, concurrent utilization reviews under federal Medicaid), on call services, community reintegration services, etc.
- Remove the Clinic Option from CMHC services. Categorize these services under another option (i.e., Other Practitioner Services) so that therapy, psychiatry and other "typical" CMHC services can be provided in any community location.
- Revise existing Medicaid services across all mental health service options (i.e., Habilitation Services, Remedial Services, Psych. Rehab. Services, Children's Mental Health Waiver, etc.) so that they are consistent with Iowa MH Code, Accreditation Standards, core required safety net services, and other changes related to Mental Health Systems Improvement efforts.

20. MHDS, IME, and IDPH work together to revise mental health benefits under SCHIP:

- Revise Hawk-I (SCHIP) to include core required safety net services and to offer a similar MH benefit package as Medicaid.
- Conduct an analysis of and work together to address administrative, policy, and funding barriers related to the provision of services to persons with co-occurring disorders.

21. MHDS conduct an analysis of Iowa Code to determine any necessary revisions/additions needed to align Code and Administrative Code with Mental Health System Improvement efforts.

- Involve relevant stakeholders when appropriate (i.e., County Staff, CMHC Rep.'s, Commission, IME, etc.).
- Make necessary revisions, additions, and deletions.
- Utilize the support and expertise of others such as consultants, legislative staff.
- Ensure accreditation standards for mental health service providers and related mental health services standards (i.e., Habilitation Services, Remedial Services, Psych.Rehab. Children's Mental Health Waiver, etc.) are consistent with Mental Health Systems Improvement recommendations
- Include an assessment and revisions to code related to voluntary and involuntary commitments.

22. Finance Plan: Utilize the Alternate Distribution Formula workgroup to address larger financial needs and comprehensive financial plan to fund the system (Core required safety net services). Have the workgroup:

- Assess how current county/state funding is being utilized (i.e., What is being matched to Medicaid, what is not, etc.).
- Determine if there is existing funding in the system that can be leveraged for Medicaid services.
- Determine state/county responsibility and role in financing the statewide system (i.e., who is responsible for what pieces? Where are responsibilities shared?).
- Analyze the feasibility of leveraging other federal dollars or other Medicaid options such as: Medicaid administrative funding, the Medicaid TEFRA Option, increasing the utilization of the HCBS Waivers, maximizing the Medicaid buy in program for people with disabilities, etc.
- Coordinate the findings of this group with MHDS, IME, and Magellan regarding related revisions, additions in services in the Medicaid State Plan or new Medicaid Administrative funding.
- Identify funding needed and address funding mechanisms for people who do not have insurance or are underinsured across all ages (i.e., includes children) within the identified priority populations.

The workgroup recommends the following as core required safety net services:

Core Services Chart	
Traditional Outpatient Clinical Services	
Service Type	**Eligible Population**
- Individual, Family, Group Therapy	Anyone, ***any age*** in need of mental health services

<table>
<tr><td>- Psychiatric/Medical Services
- Medication Management
- Psychological Services:
- Testing, Evaluation, etc</td><td></td></tr>
<tr><th colspan="2">Emergency Services</th></tr>
<tr><th>Service Type</th><th>Eligible Population</th></tr>
<tr><td>Examples:

- 24/7 Crisis/emergency Response
- 24/7 Mobile Response
- Screening Services
- Crisis Case Management/ coordination of care
- In-home crisis stabilization
- Out of home crisis stabilization
- Explore standardized models such as CIT
NOTE: The recommended Acute Mental Health Task Force will determine what the model/ definitions/core services for emergency services.</td><td>Individuals of all ages who are experiencing a mental health related crisis</td></tr>
<tr><th colspan="2">Specialized Community Based Services for Youth</th></tr>
<tr><th>Service Type</th><th>Eligible Population</th></tr>
<tr><td>General Community Based Services (CBS) following a System of Care model and a Wraparound approach. Examples include but are not limited to:
- Intensive case management
- In-home supports
- Behavioral health aides
- School Based Services
- Parent Support Services
- Early identification and assessment
- Transitional Services
- Psychosocial Group Services (IE: day treatment; after school programs; etc.).

Note: CBS services for youth are similar to CSS Services for adults. CBS Services are provided anywhere youth and families need them: home, school, community, etc.

Decisions need to be made about which CBS</td><td>Youth Experiencing Serious Emotional Disturbance (SED)</td></tr>
</table>

services are required as core service, which services are optional.	
Specialized Community Based Services for Adults	
Service Type	**Eligible Population**
General Community Support Services which includes: - Intensive Case Management Services - Supported Community Living Services – standardize the model (IE: Medicaid, Definitions in code, etc. utilize the same language and same model). - Peer Support Services - Psychosocial Rehab. Group/day Treatment services **Note:** These are services that can be provided anywhere adults need them: home, work, community, etc. Decisions need to be made about what is a required core service, what is optional.	Adults experiencing serious Mental Illness (SMI)
Other Service Areas	
Service Type	Eligible Population
Education/Training in Co-Occurring Disorders (i.e.: Mental Health/Substance Abuse). Education/Training in other Co-Occurring Disorders (i.e.: Mental Health/ MR&DD).	All behavioral health services (i.e.: mental health, substance abuse, etc.). All providers (i.e.: mental health, substance abuse, corrections, etc.)
Outreach and Public Education	General Public

D. Standards & Accreditation

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Recommendations

1. Begin major revision of Ch. 24 accreditation standards to address the wide array of issues listed in the preceding section. It was thought unlikely that the workgroup could or should propose a draft of specific accreditation standards. The workgroup did believe it within its charge to develop both general as well as more specific and targeted recommendations that would be incorporated into standards and used to shape their direction and application.
2. Develop current standards specific to CMHCs.
3. Include new standards that support a fundamental continuous quality improvement process similar to that seen by the Joint Commission on Accreditation of Healthcare Organizations to restore governance, administrative and services sections that more completely detail standards specific to CMHCs.
4. Delineate standards be comprehensive to the operations of a CMHC addressing issues that have been identified earlier and the process of accreditation should reflect the importance of having strong, consistent standards for CMHCs across Iowa
5. CMHC standards should incorporate expectations for community ownership and responsiveness.
6. Community planning, consultation and education services are restored to the definitions of mental health services.
7. CMHCs have a defined linkage to the states mental health authority and the counties in their service areas.
8. CMHCs should develop and obtain affiliation agreements with other providers of core mental health services as they carry a responsibility of providing or partnering with others to provide core mental health services.
9. Community mental health centers establish written statements of understanding that define the relationship and the role of service coordination where a close continuing interaction occurs.
10. Accreditation activities should ensure that CMHCs establish and continuously monitor staff credentials and scope of practice provided to served consumers
11. Staff improvement should continue to serve as an important standard establishing the staff development plan, organizational plans and resources.
12. Supervision, consultation and peer review be defined and incorporated within CMHCs continuous quality improvement system.
13. MHDS Accreditation staff should be adequately resourced to carry out more comprehensive quality assurance reviews and accreditation site visits.
14. MHDS Accreditation staff should be provided with standardized tools and processes

15. Accreditation standards should reflect and allow for service information to be recorded and accessed electronically
16. Accreditation standards provide for the development of outcome and process indicators on which continuous quality improvement occurs.
17. An Accreditation implementation work group is formed to develop a working draft of new standards for distribution, review, discussion, further revision and submission for adoption
18. The Department of Health is actively involved in the process to ensure that there is increasing compatibility in the processes to be used and standards that are developed between DHS and DPH.
19. Funding be provided to adequately fund a community mental health center accreditation and continuous quality improvement team.

E. Co-Occurring Disorders

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The workgroup identified four major areas for improvement:

a. Incorporation of a vision statement for a comprehensive, continuous and integrated system of care for individuals with co-occurring disorders.
b. The development a charter document for Co-occurring disorders systems development and expansion.
c. Ongoing participation in a Co-Occurring Disorders Policy Academy
d. Ongoing consultation on systems development work

F. Evidence-based Practices

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Family Member

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Background of Evidence-Based Practices

Although the term "evidence based practice" has been used with increasing frequency over the past decade, it is still a relatively new term in health care and disabilities services. The work group put forth much effort to review various definitions of EBP to clarify the meaning of this term.

A summary of the various definitions and conceptions of the term "evidenced based practice" includes:

- Interventions for which there is consistent scientific evidence showing that they improve client outcomes (Drake,RE, et al, *Psychiatric Services*, 2001).
- An intervention with a body of evidence (i.e., rigorous research studies with specific target populations and client outcomes), specific implementation criteria (e.g., treatment manual), and a track record showing that the practice can be implemented in different setting (Bond G., et al, *Psychiatric Services*, 2001).
- Evidence-based practice is the integration of best research evidence with clinical expertise and patient values (Sackett et al, 2000; *Institute of Medicine*, 2001).
- Evidenced-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, *Policy Statement on EBP*, 2007).
- Evidenced-based medicine involves evaluating rigorously the effectiveness of healthcare interventions, disseminating the results evaluation and using those findings to influence clinical practice (Appleby J., Walshe K., and Ham C., 1995).
- Evidenced-based medicine is a set of strategies derived from developments in information technology and clinical epidemiology designed to assist the clinician in keeping up to date with the best available evidence (Geddes, 2000).
- It (EBP) recognizes that health care is individualized and ever changing and involves uncertainties and probabilities… Ultimately evidence-based practice is the formalization of the care process that the best clinicians have practiced for generations (McKibbon KA., 1998).

It is important to realize the varying definitions can be very different in terms of implementation and actual clinical practice. There are also differences between systems level evidenced- based practices and individualized client specific practices. The definitions outlined in the third and fourth bullets above are the most commonly accepted definitions for EBP's within the mental health services field.

Work group Parameters for assessment, choice, and prioritization of EBP's - In an effort to provide structure to the review of potential EBP's, each EBP was evaluated according to the following parameters:

- Clarity of Construct: To what extent is there clear agreement on what this means? Is there a manual to follow? Is it a circumscribed, teachable practice that can replicated across sites?
- Impact: How much of an effect will an initiative in this area likely to have? How many people will it likely affect?
- Need: How critical is the need for this service/intervention or initiative at this time?
- Evidence- Base: To what extent has the practice been demonstrated to yield good outcomes in rigorous studies across multiple sites?
- Diversity: Will this initiative impact diverse populations across the state (e.g. across cultural groups, age groups, socio-economic groups, etc.)?
- Feasibility: What is the likelihood that the initiative can actually succeed if undertaken?
- Opportunity: To what extent does this initiative make sense at this time in terms of dovetailing with other initiatives?
- Affordability: What are the realistic estimates of short-term (i.e., start up) and long-term costs?

Conclusions - In keeping with the legislative direction outlined in HF 909 – recommendations are provided below for the implementation of two evidence-based practices (EBPs) per year over the next three years for adults with serious mental illness and children and adolescents with serious emotional disturbances (i.e., a total of six practices over 3 years). However, there is universal concern among the workgroup that anything near full implementation of this many practices might overwhelm the capabilities of the system. Strategies to address this concern fall into two general areas, both of which may be applicable:

1) reduce the number of EBP's/year, e.g., to one/year for each population
2) clarify what is meant by "implementation", emphasizing that implementation doesn't have to be statewide. Rather, it may take the form of demonstration or pilot projects.

Evidence Based Practice Recommendations

The recommended EBP's for adults and children are summarized below:

EBPs for Adults

Service Delivery Model:

COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEM OF CARE MODEL

Year 1:

1. Integrated treatment for Co-occurring Mental Illness and Substance Use Disorders

2. Peer Support

Year 2:

1. Supported Employment
2. Illness Management and Recovery (including CBT)

Year 3:
1. Assertive Community Treatment
2. Family Psychoeducation

EBPs for Children and Adolescents

Service Delivery Model:

SYSTEM OF CARE MODEL

Year 1:
1. School-based Mental Health Services

2. Intensive Case Management with Wraparound

Year 2:
1. Parent Support, Education, and Training

2. In-Home and Community Based Services and Supports

Year 3:
2. Functional Family Therapy

I. EBPs for Adults with Serious Mental Illness (Detailed Description):

Year 1:

A. Integrated Treatment for Co-occurring Disorders
The EBP workgroup is fully supportive of the overall "Comprehensive, Continuous, Integrated System of Care Model" as explicated by Minkof. One specific implementation model is clearly laid out in the "Integrated Dual Diagnosis Toolkit" by SAMHSA. The workgroup supports expanded implementation of this model.

Critical components of the model include:

- *Integrated services*: Clinicians provide services for both mental illness and substance use at the same time.
- *Knowledge about alcohol and drug use, as well as mental illnesses*: Clinicians know the effects of alcohol and drugs and their interactions with mental illness.
- *Assessment*: Consumers collaborate with clinicians to develop an individualized treatment plan for both substance use disorder and mental illness.
- *Stage-wise treatment*: People go through a process over time to recover and different services are helpful at different stages of recovery.
- *Motivational treatment*: Clinicians use specific listening and counseling skills to help consumers develop awareness, hopefulness, and motivation for recovery. This is important for consumers who are demoralized and not ready for substance abuse

Ongoing workforce development in core competencies in each of these areas must be pursued.

Fidelity assessment for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Peer Support
The EBP workgroup recommends the expansion of peer support services.

Although the evidence-basis for the effectiveness of peer support not been as strongly established in rigorous research studies as other recommended EBP's for adults, it is growing and there is increasing consensus and enthusiasm for the model, especially as pursued via the "Georgia Model" of peer support. This model revolves around "Certified Peer Specialists" (CPS). The workgroup recommends that the job responsibilities and activities of the CPS be built upon that which is in use in Georgia – and detailed in the appendix.

Peer support specialists should play an increased role in crisis intervention services, (e.g., in emergency room settings).

The MHDS should work with IME to ensure providers are appropriately reimbursed for peer support services.

The division must review and revise accreditation standards to describe the role, training, and quality assurance requirements of the CPS position.

Adults, Year 2:

A. Supported Employment
The EBP workgroup concluded that employment is a critical piece of recovery, and supported employment for adults with SMI is an evidence-based model that is being under-utilized in Iowa. With the introduction of the Medicaid Habilitation Option, and the CMS-funded Money Follows the Person Initiative/ Consumer Choice Option grant, it is felt that this is a good time to pursue this.

Supported employment revisions under the MR and BI Medicaid waivers need to be made consistent with or incorporated into the Habilitative services. The Habilitative services rules need to be reviewed and revised so as to be optimally consistently with the evidence-based practice model as described in the SAMSHA Supportive Employment toolkit.

The Workgroup recommends that MHDS and IME ensure that providers are being appropriately reimbursed for supported employment services, and the MHDS must expand collaboration with Division of Vocational Rehabilitation.

Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA Supported Employment toolkit

Critical components and core principles of this supported employment model include:

- *Eligibility is based on consumer choice.* No one is excluded who wants to participate.
- *Supported employment is integrated with treatment:* Employment specialists coordinate plans with the treatment team: the case manager, therapist, psychiatrist, etc.
- *Competitive employment is the goal.* The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- *Job search starts soon after a consumer expresses interest in working.* There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like prevocational work units, transitional employment, or sheltered workshops).
- *Follow-along supports are continuous.* Individualized supports to maintain employment continue as long as consumers want the assistance.
- *Consumer preferences are important.* Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

Fidelity assessment for this model should be conducted across all CMHC's on a regular (e.g., at time of accreditation) basis.

B. Illness Management and Recovery
"Illness management and Recovery" refers to a set of illness management techniques directed at adults with serious mental illness … (fill in)

Adults Year 3:

A. Assertive Community Treatment (ACT)
Iowa currently has 5 ACT teams serving ~ 250 clients. It is estimated that the number that would qualify for and benefit from ACT in Iowa is ~ 2000 (based on an expected need of 2.2% of mental health users, or 0.06% of adult population as per Cuddeback et al). It is estimated that ~ 15 ACT teams would be required for statewide access to ACT in Iowa. The workgroup recommended the implementation of one new team per year over the next 10 years.

The two major barriers to full statewide implementation involve funding and workforce issues. With an appropriate reimbursement strategy, ACT teams should pay for themselves within two years of start-up. Start-up costs are estimated at 500K for year 1 and 250K for year 2. Medicaid dollars are typically the primary source of payment for ACT. Payment for ACT services should be incorporated into Iowa's state Medicaid plan as a required rather than optional service.

As the availability of psychiatrists is a potentially rate limiting factor, accreditation standards that allow for nurse practitioners and/or physician's assistants to fill the psychiatric role should be pursued.

A key to the success of this "roll out" would be adequate training and support, e.g., in the form of an ACT TA center. Workforce development efforts must be focused on developing competencies in the core principles as outlined in the SAMHSA Assertive Community Treatment toolkit.

B. Family Psychoeducation

Family psychoeducation is an evidence-based program that can reduce relapse rates and facilitate recovery of persons who have mental illness. Psychoeducation is delivered by health care professionals, generally takes place over several months, and is linked to the treatment being received by the family member who has a mental illness. The main goals of working with families are to improve the quality of life for the person who has mental illness through collaborative treatment and management; and to reduce the stress and burden of family members while supporting them in their efforts to aid in the recovery of their loved one. Family psychoeducation has been shown to be useful in schizophrenia. The evidence base for other adult psychiatric disorders has been less well established.

The main barrier to family psychoeducation is typically concerns (real or perceived) about whether this activity meets typical standards for reimbursement. As is the case with parent training for conduct disorders, the evidence-based practice requires services not to the identified client – but rather to the supporters of that client. This can present a problem with respect to reimbursement. It is critical that barriers to funding for family psychoeducation be addressed, so that traditional third party reimbursement, e.g., from Medicaid, can be used to finance it.

It is recommended that training in core competencies for family psychoeducation in Iowa follow the model as laid out in the Family Psychoeducation toolkit from SAMHSA.

I. EBPs for Children and Adolescents (Detailed Description):

Year 1:

A. School-based Mental Health Services
The capacity to identify and appropriately treat youth with mental health needs should be enhanced in schools, because that's where the children are. Those most in need are often those most difficult to engage in traditional treatment settings. Research also indicates that school based mental health services are an effective means for early identification, intervention, and treatment of mental health needs of youth.

The school based service initiative will concentrate on:

- Improved collaboration and coordination at that state agency level between DHS-MHDD, the Department of Education, and the Area Educational Agencies (AEAs) with the goal of state level efforts extending to local school districts, AEA's, special education services, Early Access, mental health service providers, and others involved in school based mental health services..

- Early identification, Screening and Assessment: A formal process for the early identification of mental health needs in youth, screening/assessment services, and coordination/referral to more formal mental health services when indicated.

- Coordination between home, school and active engagement of parents of youth.

- Mental Health education, training, consultation, and other support to educational staff about identifying mental health needs in youth and supporting youth with mental health needs in the classroom.

- Training in core clinical competencies of specific evidence-based interventions for priority disorders must be available in a practical manner. This should focus on:

    - parent education and support (e.g., Parent Child Interaction Therapy)
    - cognitive behavioral and interpersonal approaches
    - early identification and intervention (e.g., ABCD II)
    - co—occurring disorders

B. Intensive Case Management/ Wraparound:

Intensive Case Management is being recommended as a step towards the implementation of the System of Care Model. Intensive case management is a model of case management, which combines the typical coordination/brokerage of service functions with the provision of intensive direct services to the child/ youth and the child/youth's family. Intensive case management services for youth and families typically follow a Wraparound Model of service delivery. This model uses the approach of "one child at a time" individualized service planning to identify what the child and family's unique strengths and needs are. Wraparound uses a team approach, includes other "key" people and/or agencies involved with the child and family in the service planning process and is typically coordinated by a case manager. The wraparound model is strengths based, family and community focused, and dedicated to keeping children and youth in the least restrictive environment appropriate to the youth's needs. The case manager coordinates all services, ensuring that the most appropriate, least restrictive services are provided in the most efficient manner.

Year 2:

A. Parent Support, Education, and Training Services (e.g., Parent Child interaction therapy, Incredible Years, parent to parent support services, etc.)

Parent Support services are services provided by trained parent educators/advocates to work with parents who have children with serious emotional disturbance. Parent Support services include education and supportive services to parents, to otherwise help parents be active participants in their child's care. Parent support services typically follow a peer-to-peer model where parents of youth with serious emotional disturbance are trained to provide the support and educational services to other parents of youth with serious emotional disturbance. Parent Support and education services can be provided individually or in a group setting.

Parent Training Services are provided to parents who have youth with SED and are typically delivered in a more formal context, often in a group setting typically following a standardized curriculum.

B. In-home and Community Based Services and Supports

In home and community based services and supports are another critical component of a System of Care Model. These services are typically provided under the supervision and/or coordination of a child's therapist and are a critical part of the child's treatment team. Providers if in home and community based services may be a bachelors or para professional level staff that have standardized training in the specific service they are providing. These services are individualized based on the unique needs of the child and family and can be provided in any community location where children and families spend their time: in the family home, at school, or in any other community location. In home and community based services may include respite care, peer support, parent support, attendant care services, behavioral health aides, community psychiatric support and treatment, in-home therapy, etc.

Year 3

A. Family Functional Therapy (FFT):

Functional Family Therapy (FFT) is a family based intervention that follows a systemic model to intervene with youth and families at risk of delinquency ***and*** out of home placement. FFT sessions are "phasic" with each phase building on another to increase engagement with the family and improve treatment outcomes.

While there are some programs in Iowa that are implementing this EBP, it is recognized as an expensive, difficult to develop practice. At the same time there appears to be evidence that the

approach is cost-effective across service systems for ***appropriately identified*** clients and families. The EBP group recommends that FFT be pursued further in terms of supporting the funding of FFT in pilot sites as well as developing statewide training for the service in select locations.

6. Other Major Recommendations

The recommendations listed above will be the subject of further study and perhaps a future report by MHDS. The other major recommendations represent a synthesis of comments and individual recommendations and not necessarily directly recommended by all of the workgroups or steering committee members.

In addition to the specific recommendations previously listed in the workgroup sections, a number of major recommendations were presented during the course of the workgroup and steering committee meetings. They were related to the:

a. role of the State Mental Health Authority
b. creation of “standing” interagency collaborative task force groups
c. need for emergency mental health crisis and disaster plan services
d. development of behavioral health workforce priorities
e. children’s mental health
f. uniform information/data systems

The recommendations listed above will be the subject of further study and perhaps a future report by MHDS. The other major recommendations represent a synthesis of comments and individual recommendations and not necessarily directly recommended by all of the workgroups or steering committee members.

APPENDICES

APPENDIX A: FY08 County Mental Health Budgets

County Name	2006 population	MH Service Fund Levy $'s	Maximum MH Levy $'s	Variance	MH Services Levy Rate	%
Statewide	2,982,085	119,434,297	125,781,915	6,347,618	-	95.0%
ADAIR	7,714	309,066	309,066	0	0.85053	100.0%
ADAMS	4,192	172,315	191,282	18,967	0.81335	90.1%
ALLAMAKEE	14,796	786,773	786,775	2	1.37965	100.0%
APPANOOSE	13,422	552,197	607,651	55,454	1.65000	90.9%
AUDUBON	6,278	595,900	595,900	0	2.42718	100.0%
BENTON	26,962	681,482	908,642	227,160	0.72709	75.0%
BLACK HAWK	126,106	5,779,823	5,779,837	14	1.55159	100.0%
BOONE	26,584	878,976	878,976	0	0.93210	100.0%
BREMER	23,837	720,183	1,294,995	574,812	0.86151	55.6%
BUCHANAN	21,045	1,292,163	1,292,163	0	1.74973	100.0%
BUENA VISTA	20,091	535,610	669,512	133,902	0.74202	80.0%
BUTLER	15,073	389,899	389,899	0	0.70511	100.0%
CALHOUN	10,437	431,560	431,560	0	0.91409	100.0%
CARROLL	20,963	1,621,769	1,800,630	178,861	2.10000	90.1%
CASS	14,124	789,047	789,047	0	1.58483	100.0%
CEDAR	18,326	968,646	968,646	0	1.20585	100.0%
CERRO GORDO	44,384	2,284,794	2,284,794	0	1.26084	100.0%
CHEROKEE	12,094	468,897	477,158	8,261	0.86623	98.3%
CHICKASAW	12,412	400,575	572,250	171,675	0.73756	70.0%
CLARKE	9,156	430,559	430,559	0	1.45124	100.0%
CLAY	16,801	402,866	402,866	0	0.51892	100.0%
CLAYTON	18,251	868,795	868,795	0	1.23879	100.0%
CLINTON	49,782	2,883,428	2,883,428	0	1.71082	100.0%
CRAWFORD	16,948	1,012,457	1,012,457	0	1.87795	100.0%
DALLAS	54,525	1,524,538	1,524,538	0	0.61967	100.0%
DAVIS	8,602	426,870	426,870	0	1.85977	100.0%
DECATUR	8,656	321,858	321,858	0	1.55855	100.0%
DELAWARE	17,848	926,948	926,948	0	1.17386	100.0%
DES MOINES	40,885	1,751,030	1,751,030	0	1.55888	100.0%
DICKINSON	16,924	412,509	412,509	0	0.29492	100.0%
DUBUQUE	92,384	4,360,995	5,165,648	804,653	1.43779	84.4%
EMMET	10,479	820,900	820,900	0	2.19525	100.0%
FAYETTE	20,996	773,024	773,024	0	1.02594	100.0%
FLOYD	16,441	610,064	610,064	0	1.06608	100.0%
FRANKLIN	10,708	358,934	358,934	0	0.65053	100.0%
FREMONT	7,737	323,535	462,193	138,658	0.92442	70.0%
GREENE	9,809	445,282	627,158	181,876	1.05997	71.0%
GRUNDY	12,320	376,434	530,188	153,754	0.66090	71.0%
GUTHRIE	11,344	614,141	614,141	0	1.28372	100.0%
HAMILTON	16,087	860,241	860,241	0	1.29708	100.0%
HANCOCK	11,680	629,221	629,221	0	1.02116	100.0%
HARDIN	17,791	850,000	898,104	48,104	1.29475	94.6%
HARRISON	15,745	920,559	920,559	0	1.65031	100.0%
HENRY	20,405	846,381	846,381	0	1.45769	100.0%

HOWARD	9,677	364,201	364,201	0	0.90862	100.0%
HUMBOLDT	9,975	473,531	473,531	0	1.06603	100.0%
IDA	7,180	300,889	300,889	0	0.90251	100.0%
IOWA	16,140	684,236	729,235	44,999	0.98000	93.8%
JACKSON	20,290	787,145	787,145	0	1.19125	100.0%
JASPER	37,409	3,120,466	3,120,466	0	2.79587	100.0%
JEFFERSON	15,945	434,068	607,300	173,232	0.85326	71.5%
JOHNSON	118,038	3,138,395	3,138,395	0	0.68713	100.0%
JONES	20,505	883,021	883,021	0	1.22306	100.0%
KEOKUK	11,081	227,995	490,075	262,080	0.50000	46.5%
KOSSUTH	16,011	736,575	1,140,780	404,205	0.83870	64.6%
LEE	36,338	2,164,720	2,164,720	0	2.25492	100.0%
LINN	201,853	8,195,141	8,195,141	0	1.10117	100.0%
LOUISA	11,858	103,362	601,189	497,827	0.20000	17.2%
LUCAS	9,543	378,000	441,861	63,861	1.55384	85.5%
LYON	11,636	248,113	248,113	0	0.48887	100.0%
MADISON	15,547	534,189	534,189	0	0.96149	100.0%
MAHASKA	22,298	1,227,887	1,227,887	0	1.67013	100.0%
MARION	32,987	923,682	1,089,896	166,214	1.00000	84.7%
MARSHALL	39,555	2,115,400	2,115,400	0	1.72296	100.0%
MILLS	15,595	609,781	609,781	0	1.00549	100.0%
MITCHELL	10,856	610,215	610,215	0	1.35988	100.0%
MONONA	9,343	375,993	375,993	0	0.89146	100.0%
MONROE	7,725	340,278	340,278	0	1.00570	100.0%
MONTGOMERY	11,365	258,818	369,740	110,922	0.65952	70.0%
MUSCATINE	42,883	2,055,392	2,055,392	0	1.43848	100.0%
O'BRIEN	14,409	570,532	570,532	0	1.08215	100.0%
OSCEOLA	6,629	195,225	195,225	0	0.65240	100.0%
PAGE	16,263	652,027	652,027	0	1.47282	100.0%
PALO ALTO	9,549	688,176	688,176	0	1.56591	100.0%
PLYMOUTH	24,906	363,771	363,771	0	0.36835	100.0%
POCAHONTAS	7,794	440,242	440,242	0	1.07569	100.0%
POLK	408,888	14,439,175	14,439,175	0	0.92743	100.0%
POTTAWATTAMIE	90,218	3,515,633	4,745,180	1,229,547	1.09603	74.1%
POWESHIEK	19,007	444,227	444,227	0	0.58060	100.0%
RINGGOLD	5,289	342,082	342,082	0	1.52769	100.0%
SAC	10,682	579,215	579,215	0	1.26625	100.0%
SCOTT	162,621	3,308,032	3,308,032	0	0.54958	100.0%
SHELBY	12,489	885,694	885,694	0	1.86539	100.0%
SIOUX	32,525	1,027,388	1,027,388	0	1.00456	100.0%
STORY	80,145	3,066,575	3,066,575	0	1.05510	100.0%
TAMA	17,890	568,799	568,799	0	0.80350	100.0%
TAYLOR	6,540	140,346	140,346	0	0.58543	100.0%
UNION	12,093	751,659	751,659	0	2.16044	100.0%
VAN BUREN	7,836	240,000	314,328	74,328	1.16885	76.4%
WAPELLO	36,010	2,276,391	2,447,733	171,342	2.72908	93.0%
WARREN	43,926	1,084,011	1,084,011	0	0.82602	100.0%
WASHINGTON	21,529	578,045	781,141	203,096	0.76099	74.0%
WAYNE	6,542	254,099	254,099	0	1.15117	100.0%
WEBSTER	38,960	2,146,797	2,146,797	0	1.73627	100.0%
WINNEBAGO	11,216	433,910	433,910	0	1.12609	100.0%
WINNESHIEK	21,263	1,178,944	1,428,756	249,812	1.51462	82.5%

WOODBURY	102,972	3,564,086	3,564,086	0	1.20460	100.0%
WORTH	7,698	441,512	441,512	0	1.19561	100.0%
WRIGHT	13,419	554,967	554,967	0	0.98983	100.0%
Total	2,982,085	119,434,297	125,781,915	6,347,618		

April 3, 2007

APPENDIX B: Levy Rates - county levies only

	FY97	FY01		FY06		FY08	
	Levy Rate	Levy Rate	% of max levy	Levy Rate	% of max levy	Levy Rate	% of max levy
Adair	$ 1.1183	$ 0.5192	56.30%	$ 0.8907	100.00%	$ 0.8505	100.00%
Adams	$ 1.1371	$ 0.9769	100.00%	$ 0.9487	100.00%	$ 0.8134	90.10%
Allamakee	$ 1.8790	$ 1.5306	100.00%	$ 1.1357	82.52%	$ 1.3797	100.00%
Appanoose	$ 2.4361	$ 2.0651	100.00%	$ 1.8000	96.09%	$ 1.6500	90.90%
Audubon	$ 2.5339	$ 0.4333	20.14%	$ 1.8379	73.05%	$ 2.4272	100.00%
Benton	$ 1.6232	$ 0.5894	55.03%	$ 0.5000	50.00%	$ 0.7271	75.00%
Black Hawk	$ 2.6285	$ 1.9277	100.00%	$ 1.6524	100.00%	$ 1.5516	100.00%
Boone	$ 1.4902	$ 1.0225	100.00%	$ 1.0558	100.00%	$ 0.9321	100.00%
Bremer	$ 2.4409	$ 0.4563	25.25%	$ 0.5996	35.23%	$ 0.8615	55.60%
Buchanan	$ 2.1933	$ 1.6694	82.41%	$ 1.5637	82.36%	$ 1.7497	100.00%
Buena Vista	$ 1.2271	$ 0.2670	27.61%	$ 0.7614	80.00%	$ 0.7420	80.00%
Butler	$ 1.0460	$ 0.7403	100.00%	$ 0.7554	100.00%	$ 0.7051	100.00%
Calhoun	$ 1.0812	$ 0.7978	100.00%	$ 0.9929	100.00%	$ 0.9141	100.00%
Carroll	$ 2.8548	$ 0.8201	36.49%	$ 1.6500	67.78%	$ 2.1000	90.10%
Cass	$ 1.9612	$ 1.6608	100.00%	$ 1.7626	100.00%	$ 1.5848	100.00%
Cedar	$ 1.7799	$ 1.0049	72.88%	$ 1.2814	100.00%	$ 1.2059	100.00%
Cerro Gordo	$ 1.9866	$ 1.5237	100.00%	$ 1.3602	100.00%	$ 1.2608	100.00%
Cherokee	$ 1.1556	$ 0.3516	38.78%	$ 0.7000	75.75%	$ 0.8662	98.30%
Chickasaw	$ 1.2264	$ 0.4293	34.95%	$ 0.9595	87.37%	$ 0.7376	70.00%
Clarke	$ 2.2047	$ 1.7197	100.00%	$ 1.4521	100.00%	$ 1.4512	100.00%
Clay	$ 0.8184	$ 0.6025	100.00%	$ 0.5700	100.00%	$ 0.5189	100.00%
Clayton	$ 1.8365	$ 1.4051	100.00%	$ 1.2730	100.00%	$ 1.2388	100.00%
Clinton	$ 2.2929	$ 1.3885	72.30%	$ 1.9087	100.00%	$ 1.7108	100.00%
Crawford	$ 2.1400	$ 1.6401	87.52%	$ 1.8400	94.18%	$ 1.8780	100.00%
Dallas	$ 1.5338	$ 0.1470	13.09%	$ 0.6191	77.02%	$ 0.6197	100.00%
Davis	$ 1.9412	$ 1.9640	100.00%	$ 1.7966	100.00%	$ 1.8598	100.00%
Decatur	$ 2.1237	$ 1.7018	100.00%	$ 1.5808	100.00%	$ 1.5586	100.00%
Delaware	$ 1.5312	$ 1.3403	97.99%	$ 1.2411	100.00%	$ 1.1739	100.00%
Des Moines	$ 2.0981	$ 1.1695	74.85%	$ 1.5713	100.00%	$ 1.5589	100.00%
Dickinson	$ 0.5734	$ 0.4512	100.00%	$ 0.3513	100.00%	$ 0.2949	100.00%
Dubuque	$ 2.6842	$ 2.1456	98.80%	$ 1.2536	70.00%	$ 1.4378	84.40%
Emmet	$ 2.3388	$ 1.6779	75.64%	$ 2.0787	87.82%	$ 2.1953	100.00%
Fayette	$ 0.7220	$ 0.9075	78.68%	$ 1.0341	100.00%	$ 1.0259	100.00%
Floyd	$ 1.4997	$ 1.1583	100.00%	$ 1.1257	100.00%	$ 1.0661	100.00%
Franklin	$ 0.9308	$ 0.4009	57.53%	$ 0.7228	100.00%	$ 0.6505	100.00%
Fremont	$ 1.4146	$ 1.2238	100.00%	$ 1.0121	78.36%	$ 0.9244	70.00%
Greene	$ 1.5764	$ 1.2814	100.00%	$ 1.5542	100.00%	$ 1.0600	71.00%

Grundy	$ 1.3127	$ 0.4191	42.03%	$ 0.9716	100.00%	$ 0.6609	71.00%
Guthrie	$ 1.7079	$ 0.9000	65.59%	$ 1.3990	100.00%	$ 1.2837	100.00%
Hamilton	$ 1.6750	$ 1.2642	100.00%	$ 1.3828	100.00%	$ 1.2971	100.00%
Hancock	$ 1.3449	$ 0.3626	32.17%	$ 1.1883	100.00%	$ 1.0212	100.00%
Hardin	$ 1.7474	$ 0.6864	50.11%	$ 1.2401	82.95%	$ 1.2948	94.60%
Harrison	$ 2.1780	$ 0.8020	51.12%	$ 1.2235	70.61%	$ 1.6503	100.00%
Henry	$ 2.0370	$ 1.1501	76.43%	$ 1.4768	100.00%	$ 1.4577	100.00%
Howard	$ 1.3558	$ 1.0509	100.00%	$ 0.9821	100.00%	$ 0.9086	100.00%
Humboldt	$ 1.3054	$ 0.6768	68.48%	$ 1.0680	100.00%	$ 1.0660	100.00%
Ida	$ 1.0798	$ 0.8639	100.00%	$ 0.6500	70.44%	$ 0.9025	100.00%
Iowa	$ 1.4338	$ 1.1020	100.00%	$ 0.9841	90.77%	$ 0.9800	93.80%
Jackson	$ 1.7729	$ 1.3375	100.00%	$ 1.2356	100.00%	$ 1.1913	100.00%
Jasper	$ 3.5482	$ 2.7231	100.00%	$ 2.2579	80.12%	$ 2.7959	100.00%
Jefferson	$ 1.5401	$ 0.7000	59.57%	$ 0.9994	77.99%	$ 0.8533	71.50%
Johnson	$ 1.2987	$ 0.9355	100.00%	$ 0.7745	100.00%	$ 0.6871	100.00%
Jones	$ 1.9346	$ 1.4021	100.00%	$ 1.2923	100.00%	$ 1.2231	100.00%
Keokuk	$ 1.4314	$ 1.0276	95.65%	$ 0.5998	53.58%	$ 0.5000	46.50%
Kossuth	$ 1.1896	$ 0.9181	70.13%	$ 1.0245	74.86%	$ 0.8387	64.60%
Lee	$ 2.8082	$ 1.1924	55.69%	$ 2.3578	100.00%	$ 2.2549	100.00%
Linn	$ 1.7453	$ 1.3256	100.00%	$ 1.1432	100.00%	$ 1.1012	100.00%
Louisa	$ 1.5389	$ 0.3973	31.80%	$ 1.0627	83.37%	$ 0.2000	17.20%
Lucas	$ 2.3925	$ 1.9819	100.00%	$ 1.4015	76.11%	$ 1.5538	85.50%
Lyon	$ 0.7975	$ 0.5043	100.00%	$ 0.5454	100.00%	$ 0.4889	100.00%
Madison	$ 1.6505	$ 0.6513	53.96%	$ 0.7581	72.00%	$ 0.9615	100.00%
Mahaska	$ 2.3306	$ 1.2065	66.59%	$ 1.7200	100.00%	$ 1.6701	100.00%
Marion	$ 1.3628	$ 1.1629	89.13%	$ 1.2218	100.00%	$ 1.0000	84.70%
Marshall	$ 2.3237	$ 0.7197	37.23%	$ 1.2396	66.65%	$ 1.7230	100.00%
Mills	$ 1.6372	$ 0.6690	59.11%	$ 1.1490	100.00%	$ 1.0055	100.00%
Mitchell	$ 1.8759	$ 1.0124	66.94%	$ 1.3958	100.00%	$ 1.3599	100.00%
Monona	$ 1.1515	$ 0.3000	34.64%	$ 0.8000	83.87%	$ 0.8915	100.00%
Monroe	$ 1.2311	$ 0.9040	100.00%	$ 0.8000	76.20%	$ 1.0057	100.00%
Montgomery	$ 1.2313	$ 0.2570	25.96%	$ 0.7504	75.57%	$ 0.6595	70.00%
Muscatine	$ 2.0403	$ 1.6290	100.00%	$ 1.2437	80.28%	$ 1.4385	100.00%
O'Brien	$ 1.2993	$ 1.0348	100.00%	$ 1.1040	100.00%	$ 1.0822	100.00%
Osceola	$ 0.7273	$ 0.5427	82.11%	$ 0.6783	100.00%	$ 0.6524	100.00%
Page	$ 1.8003	$ 0.3306	25.01%	$ 0.9000	63.77%	$ 1.4728	100.00%
Palo Alto	$ 1.9447	$ 1.2831	79.39%	$ 1.6712	100.00%	$ 1.5659	100.00%
Plymouth	$ 0.4599	$ 0.3026	81.46%	$ 0.3912	100.00%	$ 0.3684	100.00%
Pocahontas	$ 1.2156	$ 0.9246	98.70%	$ 1.1442	100.00%	$ 1.0757	100.00%
Polk	$ 1.7230	$ 1.2639	100.00%	$ 1.0320	100.00%	$ 0.9274	100.00%
Pottawattamie	$ 2.6337	$ 0.6357	34.59%	$ 1.0603	63.22%	$ 1.0960	74.10%
Poweshiek	$ 0.9691	$ 0.6474	100.00%	$ 0.5977	100.00%	$ 0.5806	100.00%
Ringgold	$ 2.1612	$ 1.8477	98.93%	$ 1.6701	100.00%	$ 1.5277	100.00%
Sac	$ 1.3535	$ 0.7981	69.13%	$ 1.0992	80.50%	$ 1.2663	100.00%
Scott	$ 0.9941	$ 0.6837	100.00%	$ 0.5798	100.00%	$ 0.5496	100.00%
Shelby	$ 2.2007	$ 0.6091	33.87%	$ 2.0656	100.00%	$ 1.8654	100.00%
Sioux	$ 1.0164	$ 1.0452	100.00%	$ 1.0608	100.00%	$ 1.0046	100.00%
Story	$ 1.9756	$ 0.5426	40.93%	$ 1.1163	100.00%	$ 1.0551	100.00%
Tama	$ 1.2180	$ -	0.00%	$ 0.8343	100.00%	$ 0.8035	100.00%
Taylor	$ 1.0011	$ 0.7349	100.00%	$ 0.6332	100.00%	$ 0.5854	100.00%
Union	$ 2.8856	$ 1.6470	71.78%	$ 2.2112	100.00%	$ 2.1604	100.00%

Van Buren	$	2.0501	$	-	0.00%	$	1.1510	76.35%	$	1.1689	76.40%
Wapello	$	3.6999	$	2.4157	74.84%	$	2.6887	87.74%	$	2.7291	93.00%
Warren	$	1.5490	$	0.9012	79.24%	$	0.8010	91.67%	$	0.8260	100.00%
Washington	$	1.1942	$	0.8641	77.00%	$	0.8068	74.00%	$	0.7610	74.00%
Wayne	$	0.8331	$	1.2201	100.00%	$	1.1705	100.00%	$	1.1512	100.00%
Webster	$	2.2628	$	1.3795	81.37%	$	1.4476	80.35%	$	1.7363	100.00%
Winnebago	$	0.8921	$	0.7387	67.81%	$	1.1083	100.00%	$	1.1261	100.00%
Winneshiek	$	2.7645	$	1.5548	70.51%	$	1.5146	80.35%	$	1.5146	82.50%
Woodbury	$	1.8126	$	0.7976	58.91%	$	1.2711	100.00%	$	1.2046	100.00%
Worth	$	1.7322	$	0.7852	54.70%	$	1.1774	87.54%	$	1.1956	100.00%
Wright	$	1.1763	$	0.9222	100.00%	$	1.0268	100.00%	$	0.9898	100.00%
Average of Rates/Statewide %	$	1.6931	$	1.0081	78.96%	$	1.1873	90.48%	$	1.1844	94.95%
Highest	$	3.70	$	2.72	100.0%	$	2.69	100.0%	$	2.80	100.0%
Lowest	$	0.46	$	-	0.0%	$	0.35	35.2%	$	0.20	17.2%
Median	$	1.64	$	0.92	81.4%	$	1.14	100.0%	$	1.08	100.0%
# at maximum levy					39			59			73

APPENDIX C: FORMULAS

Factors of Present Formula	Adjustments to the Present Formula	Factors of Alternative Formula Proposed
Eligibility criteria – to be eligible for funding, each county must prepare an application, provide statistical information and meet the reporting deadline -*98 of 99 counties met the reporting deadline FY 07*	**Eligibility criteria** – same as present formula	**Eligibility criteria** – same as present formula
Eligibility criteria - Code requires levy rate to be at least 70% of maximum to receive funds. *92 of 99 counties were above 70% for FY 07. 67 counties levied at 100%*	**Eligibility criteria** – Each county would be required to levy at 100% of maximum except where the levy rate will exceed $3.00 per $1000 valuation (or other maximum rate to be determined)	**Eligibility criteria** – Each county would be required to levy at 100% of maximum except where the levy rate will exceed $3.00 per $1000 valuation (or other maximum rate to be determined)
Eligibility criteria – The MH fund balance has to be less than 25%. *67 counties had fund balances below 25% for FY 07.*	**Eligibility criteria** – The MH fund balance has to be less than 15%.	**Eligibility criteria** – The MH fund balance has to be less than 15%.
1) **population** estimate - *based on each county's percentage of total state population using most recent census estimate*	1) **population** estimate - *based on each county's percentage of total state population using most recent census estimate*	Use **MH/DD client #'s X case rate** ***There will also be a need for an allocation for services outside the case rate – for example: prevention and administration costs.*** *Eliminates legal settlement.* *Meets the needs of the people served.* *Money follows the person.* *Simplification, flexibility* *Can be adjusted quarterly*
2) **poverty** population data – based on each county's percentage of total state poverty population.	2) **poverty** population data – based on each county's percentage of total state poverty population. Use the 2-year-old fund balance instead of the 1-year-old fund balance in the formula. The allowed growth will be calculated by Jan. 1 for the subsequent fiscal year. We recommend the changes be passed in FY 08 legislation so it will be effective for the FY09 allowed growth calculation.	*Counties should be able to calculate the dollars they may receive at the beginning of the year rather than having to wait until the middle of the year to know how much money they have to work with.* *Requires having data systems and definitions in place. It will be imperative to have – an unduplicated count of clients per county and a case rate methodology established.*
3) per capita net county expenditures not used in 08	Not applicable	Not applicable